



## **RESOURCE AND PATIENT MANAGEMENT SYSTEM**

### **IHS Clinical Reporting System (CRS 2008) (BGP V. 8.0)**

### **HEDIS Report Performance Measure List and Definitions September 2007**

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## Revision History

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## CRS DENOMINATOR DEFINITIONS

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- ***For all denominators:***
  - All patients with name “DEMO,PATIENT” will be automatically excluded for all denominators.
  - For all measures except as noted, patient age is calculated as of the beginning of the Report Period.
- ***Active Clinical Population for National GPRA Reporting***
  - Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the CRS 2008 User Manual for listing of these clinics.
  - Must be alive on the last day of the Report Period.
  - Must be American Indian/Alaska Native (AI/AN) (defined as Beneficiary 01).
  - Must reside in a community specified in the site’s GPRA community taxonomy, defined as all communities of residence in the defined CHS catchment area.
- ***Active Clinical Population for Local Reports***
  - Must have two visits to medical clinics in the past three years. Chart reviews and telephone calls from these clinics do not count; the visits must be face-to-face. At least one visit must be to a core medical clinic. Refer to the CRS 2008 User Manual for listing of these clinics.
  - Must be alive on the last day of the Report Period.
  - User defines population type: AI/AN patients only, non AI/AN or both.
  - User defines general population: single community; group of multiple communities (community taxonomy); user-defined list of patient (patient panel); or all patients regardless of community of residence.
- ***User Population for National GPRA Reporting***
  - Must have been seen at least once in the three years prior to the end of the time period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
  - Must be alive on the last day of the Report Period.
  - Must be American Indian/Alaska Native (AI/AN) (defined as Beneficiary 01).
  - Must reside in a community specified in the site’s GPRA community taxonomy, defined as all communities of residence in the defined CHS catchment area.
- ***User Population for Local Reports***
  - Must have been seen at least once in the three years prior to the end of the time period, regardless of the clinic type, and the visit must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
  - Must be alive on the last day of the Report Period.
  - User defines population type: AI/AN patients only, non AI/AN or both.
  - User defines general population: single community; group of multiple communities (community taxonomy); user-defined list of patient (patient panel); or all patients regardless of community of residence.
- ***Active Clinical CHS Population for National GPRA Reporting (used only for CHS-only sites)***
  - Must have 2 CHS visits in the 3 years prior to the end of the Report Period and the visits must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
  - Must be alive on the last day of the Report period.
  - Must be American Indian/Alaska Native (AI/AN) (defined as Beneficiary 01). This data item is entered and updated during the patient registration process.
  - Must reside in a community included in the site’s “official” GPRA community taxonomy, defined as all communities of residence in the CHS catchment area specified in the community taxonomy specified by the user.
- ***Active Clinical CHS Population for Local Reports (used only for CHS-only sites)***
  - Must have 2 CHS visits in the 3 years prior to the end of the Report Period and the visits must be either ambulatory (including day surgery or observation) or a hospitalization; the rest of the service categories are excluded.
  - Must be alive on the last day of the Report period.
  - User defines population type: AI/AN patients only, non AI/AN or both.
  - User defines general population: single community; group of multiple communities (community taxonomy); user-defined list of patient (patient panel); or all patients regardless of community of residence.

## ABOUT THE CRS HEDIS REPORT

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures designed to ensure that purchases and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. HEDIS also includes a standardized survey of consumers' experiences that evaluated plan performance in areas such as customer service, access to care, and claims processing. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA).

NCQA has developed a HEDIS Software Certification program that ensures the integrity of commercial software products that produce HEDIS results. By becoming NCQA-Certified, sites can help improve the accuracy of reporting measures and produce more reliable and comparable HEDIS results. IHS sites wanting to become NCQA-Certified may run the CRS HEDIS report, which contains most but not all of the HEDIS measures. While the majority of the CRS measures adhere strictly to the HEDIS logic, others have been modified to reflect how IHS provides care to its patients. Periodically, additional HEDIS measures are added to the CRS HEDIS report.

For additional information about HEDIS, visit the web site at <http://web.ncqa.org/tabid/59/Default.aspx> or the NCQA site at <http://www.ncqa.org/index.htm>.

## CRS HEDIS REPORT PERFORMANCE MEASURE TOPICS AND DEFINITIONS

The performance measure topics and their definitions that are included in the CRS 2008 Version 8.0 HEDIS Performance Report are shown in the table below.

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<b>Childhood Immunizations</b> Epidemiology Program/ Amy Groom, MPH  Same as Childhood Immunizations in CRS Selected Measures Report but includes less measures	<i><b>Changes from Version 7.0 Patch 1, as noted below.</b></i> <b>Denominator:</b> 1) Active Clinical patients ages 19-35 months at end of Report Period. <b>Numerators:</b> 1) Patients with 4 doses of DTaP, or who have evidence of the disease, a contraindication, or a documented refusal. 2) Patients with 3 doses of Polio, or who have evidence of the disease, a contraindication, or a documented refusal. 3) Patients with 1 dose of MMR, or who have evidence of the disease, a contraindication, or a documented refusal. 4) Patients with 3 doses of HiB, or who have evidence of the disease, a contraindication, or a documented refusal. 5) Patients with 3 doses of Hepatitis B, or who have evidence of the disease, a contraindication, or a documented refusal. 6) Patients with 1 dose of Varicella, or who have evidence of the disease, a contraindication, or a documented refusal. 7) Patients with 4 doses of Pneumococcal conjugate, or who have evidence of the disease, a contraindication, or a documented refusal. 8) Patients who have received the 4:3:1:3:3:1 combination (i.e. 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B, 1 Varicella), including refusals, contraindications, and evidence of disease. 9) Patients who have received <i><b>the 4:3:1:3:3:1:4 combination (renamed from "all childhood immunizations")</b></i> (i.e. 4 DTaP, 3 Polio, 1 MMR, 3 HiB, 3 Hepatitis B, 1 Varicella, and 4 Pneumococcal), including refusals, contraindications, and evidence of disease. <b>Definitions:</b> 1) <b>Patient Age:</b> Since the age of the patient is calculated at the beginning of the Report Period, the age range will be adjusted to 7-23 months at the beginning of the Report Period, which makes the patient between the ages of 19-35 months at the end of the Report Period. 2) <b>Timing of Doses:</b> Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization.

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<b>Childhood Immunizations (cont'd)</b> Epidemiology Program/ Amy Groom, MPH	<p><b>3) Dosage and Types of Immunizations:</b></p> <p>A) <b>4 Doses of DTaP:</b> 1) 4 DTaP/DTP/Tdap; 2) 1 DTaP/DTP/Tdap and 3 DT/Td; 3) 1 DTaP/DTP/Tdap and 3 each of Diphtheria and Tetanus; 4) 4 DT and 4 Pertussis; 5) 4 Td and 4 Pertussis; or 6) 4 each of Diphtheria, Tetanus, and Pertussis.</p> <p>B) <b>3 Doses of Polio:</b> 1) 3 OPV; 2) 3 IPV; or 3) combination of OPV &amp; IPV totaling 3 doses.</p> <p>C) <b>1 Dose of MMR:</b> 1) MMR; 2) 1 M/R and 1 Mumps; 3) 1 R/M and 1 Measles; or 4) 1 each of Measles, Mumps, and Rubella.</p> <p>D) 3 doses of Hep B OR 2 doses IF documented with CPT 90743.</p> <p>E) 3 doses of HIB</p> <p>F) 1 dose of Varicella</p> <p>G) 4 doses of Pneumococcal</p> <p><b>5) Refusal, Contraindication, and Evidence of Disease Information:</b> Refusals, evidence of disease, and contraindications for individual immunizations will also count toward meeting the definition, as defined below.</p> <p>A) Each immunization must be refused and documented separately. For example, if a patient refused Rubella only, then there must be an immunization, contraindication, or separate refusal for the Measles and Mumps immunizations.</p> <p>B) For immunizations where required number of doses is &gt;1, only one refusal is necessary to be counted in the numerator. For example, if there is a single refusal for Hepatitis B, the patient will be included in the numerator.</p> <p>C) Evidence of disease will be checked for at any time in the child's life (prior to the end of the Report period.)</p> <p>D) To be counted as a refusal, a patient must have a REF refusal in PCC or a Parent or Patient Refusal in the IZ program for any of the immunizations in the numerator. For example, if a patient refused Rubella only but had immunizations for Measles and Mumps, the patient would be counted as having a refusal for MMR.</p> <p>E) To be counted as evidence of disease/contraindication/NMI refusal, a patient must have evidence of disease, a contraindication, or an NMI refusal for any of the immunizations in the numerator. For example, if a patient was Rubella immune but had a Measles and Mumps immunization, the patient would be counted as having evidence of disease for MMR.</p> <p><b>6) Refusal Definitions:</b> Parent/Patient Refusal in Immunization package or PCC Refusal type REF or NMI for IZ codes: <b>DTaP:</b> 20, 50, 106, 107, 110, 120; <b>DTP:</b> 1, 22, 102; <b>Tdap:</b> 115; <b>DT:</b> 28; <b>Td:</b> 9, 113; <b>Tetanus:</b> 35, 112; <b>Pertussis:</b> 11; <b>OPV:</b> 2, 89; <b>IPV:</b> 10, 89, 110, 120; <b>MMR:</b> 3, 94; <b>M/R:</b> 4; <b>R/M:</b> 38; <b>Measles:</b> 5; <b>Mumps:</b> 7; <b>Rubella:</b> 6; <b>HiB:</b> <i>17</i>, 22, 46-49; 50, 51, 102, 120; <b>Hepatitis B:</b> 8, 42-45, 51, 102, 104, 110; <b>Varicella:</b> 21, 94; <b>Pneumococcal:</b> 33, 100, 109.</p> <p><b>7) Immunization Definitions: NOTE:</b> In the definitions for all immunizations shown below, the Immunization Program Numerators will include only CVX and CPT codes.</p> <p>A) <b>DTaP:</b> 1) Immunization (CVX) codes: 20, 50, 106, 107, 110, 120; 2) POV V06.1; 3) CPT: 90698, 90700, 90721, 90723. <i>(Deleted CPT 90749 since it is a generic (unlisted) code.)</i>  <b>DTaP contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></p> <p>B) <b>DTP:</b> 1) Immunization (CVX) codes: 1, 22, 102; 2) POV: V06.1, V06.2, V06.3; 3) CPT: 90701, 90711 (old code), 90720; 4) Procedure 99.39. <b>DTP contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></p> <p>C) <b>Tdap:</b> 1) Immunization (CVX) code: 115; 2) CPT 90715. <b>Tdap contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></p> <p>D) <b>DT:</b> 1) Immunization (CVX) code 28; 2) POV V06.5; 3) CPT 90702. <b>DT contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></p> <p>E) <b>Td:</b> 1) Immunization (CVX) code 9, 113; 2) POV V06.5; 3) CPT 90714, 90718. <b>Td contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<b>Childhood Immunizations (cont'd)</b> Epidemiology Program/ Amy Groom, MPH	<p>F) <b>Diphtheria:</b> 1) POV V03.5; 2) CPT 90719; 3) Procedure 99.36. Diphtheria evidence of disease definitions: POV or PCC Problem List (active or inactive) V02.4, 032*. <i><b>Diphtheria contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>G) <b>Tetanus:</b> 1) Immunization (CVX) codes: 35, 112; 2) POV V03.7, 3) CPT 90703; 4) Procedure 99.38. Tetanus evidence of disease definition: POV or PCC Problem List (active or inactive) 037*. <i><b>Tetanus contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>H) <b>Pertussis:</b> 1) Immunization (CVX) code 11; 2) POV V03.6; 3) Procedure 99.37. Pertussis evidence of disease definition: POV or PCC Problem List (active or inactive) 033*. <i><b>Pertussis contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>I) <b>OPV:</b> 1) Immunization (CVX) codes: 2, 89; 2) CPT 90712. OPV contraindication definitions: POV: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; <i><b>or Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>J) <b>IPV:</b> 1) Immunization (CVX) codes: 10, 89, 110, 120; 2) POV V04.0, V06.3; 3) CPT: 90698, 90711 (old code), 90713, 90723; 4) Procedure 99.41. IPV evidence of disease definitions: POV or PCC Problem List (active or inactive): V12.02, 045*, 138, 730.70-730.79. <i><b>IPV contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis" or "Neomycin Allergy."</b></i></p> <p>K) <b>MMR:</b> 1) Immunization (CVX) codes: 3, 94; 2) POV V06.4; 3) CPT: 90707, 90710; 4) Procedure 99.48. MMR contraindication definitions: POV: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; <i><b>or Immunization Package contraindication of "Anaphylaxis," "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</b></i></p> <p>L) <b>M/R:</b> 1) Immunization (CVX) code 4; 2) CPT 90708. <i><b>M/R contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>M) <b>R/M:</b> 1) Immunization (CVX) code 38; 2) CPT 90709 (old code). <i><b>R/M contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>N) <b>Measles:</b> 1) Immunization (CVX) code 5; 2) POV V04.2; 3) CPT 90705; 4) Procedure 99.45. Measles evidence of disease definition: POV or PCC Problem List (active or inactive) 055*. <i><b>Measles contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>O) <b>Mumps:</b> 1) Immunization (CVX) code 7; 2) POV V04.6; 3) CPT 90704; 4) Procedure 99.46. Mumps evidence of disease definition: POV or PCC Problem List (active or inactive) 072*. <i><b>Mumps contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>P) <b>Rubella:</b> 1) Immunization (CVX) code 6; 2) POV V04.3; 3) CPT 90706; 4) Procedure 99.47. Rubella evidence of disease definitions: POV or PCC Problem List (active or inactive) 056*, 771.0. <i><b>Rubella contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>Q) <b>HiB:</b> 1) Immunization (CVX) codes: <i><b>17</b></i>, 22, 46-49, 50, 51, 102, 120; 2) POV V03.81; 3) CPT: 90645-90648, 90698, 90720-90721, 90748. HiB evidence of disease definitions: POV or PCC Problem List (active or inactive) 038.41, 041.5, 320.0, 482.2. <i><b>HiB contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>R) <b>Hepatitis B:</b> 1) Immunization (CVX) codes: 8, 42-45, 51, 102, 104, 110; 2) CPT: 90636, 90723, 90731 (old code), 90740, 90743-90748, <i><b>G0010, Q3021, Q3023</b></i>. Hepatitis B evidence of disease definitions: POV or PCC Problem List (active or inactive): V02.61, 070.2, 070.3. <i><b>Hepatitis B contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>S) <b>Varicella:</b> 1) Immunization (CVX) codes: 21, 94; 2) POV V05.4; 3) CPT: 90710, 90716. Varicella evidence of disease definitions: 1) POV or PCC Problem List (active or inactive) 052*, 053* <i><b>or 2) Immunization Package contraindication of "Hx of Chicken Pox" or "Immune."</b></i> Varicella contraindication definitions: POV: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; <i><b>or Immunization Package contraindication of "Anaphylaxis," "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</b></i></p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<b>Childhood Immunizations (cont'd)</b> Epidemiology Program/ Amy Groom, MPH	<p>T) <b>Pneumococcal:</b> 1) Immunization (CVX) codes: 33 Pneumo Polysaccharide; 100 Pneumo Conjugate; 109 Pneumo NOS; 2) POV: V06.6; V03.82; 3) CPT: 90669, 90732, <i><b>G0009, G8115.</b></i></p> <p><i><b>Pneumococcal contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p><b>Patient List:</b> List of patients without ALL childhood immunizations, indicating which immunizations not received. NOTE: Because age is calculated at the beginning of the Report Period, the patient's age on the list will be between 7-23 months.</p>
<b>Adolescent Immunizations</b> Dr. Scott Hamstra/Amy Groom, MPH, Epidemiology Program  Same as Adolescent Immunizations in CRS Selected Measures Report but includes less measures	<p><i><b>Changes from Version 7.0 Patch 1, as noted below.</b></i></p> <p><b>Denominators:</b> 1) Active Clinical patients age 13.</p> <p><b>Numerators:</b> 1) Patients who have received 2 doses of MMR ever, including refusals, contraindications, and evidence of disease.</p> <p>2) Patients who have received 3 doses of Hepatitis B ever, including refusals, contraindications, and evidence of disease.</p> <p>3) Patients who have received 1 dose of Varicella ever, including refusals, contraindications, and evidence of disease.</p> <p>4) Patients who have received the 2 MMR, 3 Hepatitis B, and one Varicella combination.</p> <p><b>Definitions:</b> 1) <b>Timing of Doses:</b> Because IZ data comes from multiple sources, any IZ codes documented on dates within 10 days of each other will be considered as the same immunization.</p> <p>2) <b>Dosage and Types of Immunizations:</b></p> <p>A) 1 dose of Td or Tdap</p> <p>B) <b>2 doses of MMR:</b> 1) 2 MMRs; 2) 2 M/R and 2 Mumps; 3) 2 R/M and 2 Measles; or 4) 2 each of Measles, Mumps, and Rubella.</p> <p>C) 3 doses of Hep B OR 2 doses IF documented with CPT 90743.</p> <p>D) 1 dose of Varicella</p> <p>3) <b>Refusal, Contraindication, and Evidence of Disease Information:</b> Refusals, evidence of disease, and contraindications for individual immunizations will also count toward meeting the definition, as defined below.</p> <p>A) Each immunization must be refused and documented separately. For example, if a patient refused Rubella only, then there must be either an immunization, contraindication, or separate refusal for the Measles and Mumps immunizations.</p> <p>B) For immunizations where required number of doses is &gt;1, only one refusal is necessary to be counted in the numerator. For example, if there is a single refusal for Hepatitis B, the patient will be included in the numerator.</p> <p>C) Evidence of disease will be checked for at any time in the child's life (prior to the end of the Report period.)</p> <p>D) To be counted as a refusal, a patient must have a REF refusal in PCC or a Parent or Patient Refusal in the IZ program for any of the immunizations in the numerator. For example, if a patient refused Rubella only but had immunizations for Measles and Mumps, the patient would be counted as having a refusal for MMR.</p> <p>E) To be counted as evidence of disease/contraindication/NMI refusal, a patient must have evidence of disease, a contraindication, or an NMI refusal for any of the immunizations in the numerator. For example, if a patient was Rubella immune but had a Measles and Mumps immunization, the patient would be counted as having evidence of disease for MMR.</p> <p>4) <b>Refusal Definitions:</b> Parent/Patient Refusal in Immunization package or PCC Refusal type REF or NMI for IZ codes: MMR: 3, 94; M/R: 4; R/M: 38; Measles: 5; Mumps: 7; Rubella: 6; Hepatitis B: 8, 42-45, 51, 102, 104, 110; Varicella: 21, 94.</p> <p>5) <b>Immunization Definitions:</b></p> <p>A) <b>MMR:</b> 1) Immunization (CVX) codes: 3, 94; 2) POV V06.4; 3) CPT: 90707, 90710; 4) Procedure 99.48. MMR contraindication definitions: POV: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; <i><b>or Immunization Package contraindication of "Anaphylaxis," "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</b></i></p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<b>Adolescent Immunizations (cont'd)</b> Dr. Scott Hamstra/Amy Groom, MPH, Epidemiology Program	<p>B) <b>M/R:</b> 1) Immunization (CVX) code 4; 2) CPT 90708. <i><b>M/R contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>C) <b>R/M:</b> 1) Immunization (CVX) code 38; 2) CPT 90709 (old code). <i><b>R/M contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>D) <b>Measles:</b> 1) Immunization (CVX) code 5; 2) POV V04.2; 3) CPT 90705; 4) Procedure 99.45. Measles evidence of disease definition: POV or PCC Problem List (active or inactive) 055*. <i><b>Measles contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>E) <b>Mumps:</b> 1) Immunization (CVX) code 7; 2) POV V04.6; 3) CPT 90704; 4) Procedure 99.46. Mumps evidence of disease definition: POV or PCC Problem List (active or inactive) 072*. <i><b>Mumps contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>F) <b>Rubella:</b> 1) Immunization (CVX) code 6; 2) POV V04.3; 3) CPT 90706; 4) Procedure 99.47. Rubella evidence of disease definitions: POV or PCC Problem List (active or inactive) 056*, 771.0. <i><b>Rubella contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>G) <b>Hepatitis B:</b> 1) Immunization (CVX) codes: 8, 42-45, 51, 102, 104, 110; 2) CPT: 90636, 90723, 90731 (old code), 90740, 90743-90748, <i><b>G0010, Q3021, Q3023</b></i>. Hepatitis B evidence of disease definitions: POV or PCC Problem List (active or inactive): V02.61, 070.2, 070.3. <i><b>Hepatitis B contraindication definition: 1) Immunization Package contraindication of "Anaphylaxis."</b></i></p> <p>H) <b>Varicella:</b> 1) Immunization (CVX) codes: 21, 94; 2) POV V05.4; 3) CPT: 90710, 90716. Varicella evidence of disease definitions: 1) POV or PCC Problem List (active or inactive) 052*, 053* <i><b>or 2) Immunization Package contraindication of "Hx of Chicken Pox" or "Immune."</b></i> Varicella contraindication definitions: POV: 279, V08, 042, 200-202, 203.0, 203.1, 203.8, 204-208; <i><b>or Immunization Package contraindication of "Anaphylaxis," "Immune Deficiency," "Immune Deficient," or "Neomycin Allergy."</b></i></p> <p><b>Patient List:</b> List of patients without ALL adolescent immunizations, indicating which immunizations not received.</p>
<b>Appropriate Treatment for Children with Upper Respiratory Infection</b> Dr. Scott Hamstra  Same topic as in CRS Selected Measures Report	<p><i><b>Changes from Version 7.0 Patch 1, as noted below.</b></i></p> <p><b>Denominator:</b> Active Clinical patients who were ages 3 months through 18 years who were diagnosed with an upper respiratory infection during the period six months (180 days) prior to the Report period through the first six months of the Report period.</p> <p><b>Numerator:</b> Patients who were NOT prescribed an antibiotic on or within three days after diagnosis. In this measure, appropriate treatment is not to receive an antibiotic.</p> <p><b>Definitions:</b> 1) <b>Age:</b> Age is calculated as follows: Children 3 months as of six months (180 days) of the year prior to the Report period to 18 years as of the first six months of the Report period.</p> <p>2) <b>Upper Respiratory Infection:</b> POV 460 or 465.*.</p> <p>3) <b>Outpatient Visit:</b> Service Category A, S, or O.</p> <p>4) <b>Antibiotic Medications:</b> A) Medication taxonomy BGP HEDIS ANTIBIOTIC MEDS. <i><b>(Replaced existing medication taxonomy with updated HEDIS taxonomy.)</b></i> (Medications are: Amoxicillin, Amox/Clavulanate, Ampicillin, Azithromycin, Cefaclor, Cefadroxil hydrate, <i><b>Cefazolin</b></i>, Cefdinir, Cefixime, Cefditoren, Cefibuten, Cefpodoxime proxetil, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, <i><b>Cephadrine</b></i>, Ciprofloxacin, Clindamycin, Dicloxacillin, <i><b>(deleted Dirithromycin)</b></i>, Doxycycline, Erythromycin, Ery E-Succ/Sulfisoxazole, <i><b>(deleted Flomefloxacin)</b></i>, Gatifloxacin, Levofloxacin, <i><b>Lomefloxacin</b></i>, Loracarbef, Minocycline, Ofloxacin, Penicillin VK, Penicillin G, Sparfloxacin, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-Sulfamethoxazol.), B) V Procedure 99.21.</p> <p><b>In order to be included in the denominator, ALL of the following conditions must be met:</b></p> <p>1) Patient's diagnosis of an upper respiratory infection (URI) must have occurred at an outpatient visit.</p> <p>2) If outpatient visit was to clinic code 30 (Emergency Medicine), it must not have resulted in a hospitalization, defined as service category H, either on the same day or the next day with URI</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<b>Appropriate Treatment for Children with Upper Respiratory Infection (cont'd)</b> Dr. Scott Hamstra	<p>diagnosis.</p> <p>3) Patient's visit must ONLY have a diagnosis of URI. If any other diagnosis exists, the visit will be excluded.</p> <p>4) The patient did not have a new or refill prescription for antibiotics within 30 days prior to the URI visit date.</p> <p>5) The patient did not have an active prescription for antibiotics as of the URI visit date. "Active" prescription defined as:                Rx Days Supply &gt;= (URI Visit Date - Prescription Date)</p> <p>If multiple visits exist that meet the above criteria, the first visit will be used.</p> <p><b>Patient List:</b> List of patients 3 months to 18 years with upper respiratory infection, with antibiotic prescription, if any.</p>
<b>Appropriate Testing for Children with Pharyngitis</b> Dr. Scott Hamstra  Same topic as in CRS Selected Measures Report	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> Active Clinical patients who were ages 2-18 years who were diagnosed with pharyngitis and prescribed an antibiotic during the period six months (180 days) prior to the Report period through the first six months of the Report period.</p> <p><b>Numerator:</b> Patients who received a Group A strep test.</p> <p><b>Definitions:</b> 1) <b>Age:</b> Age is calculated as follows: Children 2 years as of six months (180 days) of the year prior to the Report period to 18 years as of the first six months of the Report period.</p> <p>2) <b>Pharyngitis:</b> POV 462, 463, or 034.0.</p> <p>3) <b>Outpatient Visit:</b> Service Category A, S, or O.</p> <p>4) <b>Antibiotic Medications:</b> A) Medication taxonomy BGP HEDIS ANTIBIOTIC MEDS. (<i>Replaced existing medication taxonomy with updated HEDIS taxonomy.</i>) (Medications are: Amoxicillin, Amox/Clavulanate, Ampicillin, Azithromycin, Cefaclor, Cefadroxil hydrate, <b>Cefazolin</b>, Cefdinir, Cefixime, Cefditoren, Ceftibuten, Cefpodoxime proxetil, Cefprozil, Ceftriaxone, Cefuroxime, Cephalexin, <b>Cephadrine</b>, Ciprofloxacin, Clindamycin, Dicloxacillin, (<i>deleted Dirithromycin</i>), Doxycycline, Erythromycin, Ery E-Succ/Sulfisoxazole, (<i>deleted Flomefloxacin</i>), Gatifloxacin, Levofloxacin, <b>Lomefloxacin</b>, Loracarbef, Minocycline, Ofloxacin, Penicillin VK, Penicillin G, Sparfloxacin, Sulfisoxazole, Tetracycline, Trimethoprim, Trimethoprim-Sulfamethoxazol.), B) V Procedure 99.21.</p> <p>5) <b>Group A Streptococcus Test:</b> A) CPT 87430 (by enzyme immunoassay), 87650-87652 (by nucleic acid), 87880 (by direct optical observation), 87081 (by throat culture); B) site-populated taxonomy BGP GROUP A STREP; and C) LOINC taxonomy.</p> <p><b><u>In order to be included in the denominator, ALL of the following conditions must be met:</u></b></p> <p>1) Patient's diagnosis of pharyngitis must have occurred at an outpatient visit.</p> <p>2) If outpatient visit was to clinic code 30 (Emergency Medicine), it must not have resulted in a hospitalization, defined as service category H, either on the same day or the next day with pharyngitis diagnosis.</p> <p>3) Patient's visit must ONLY have a diagnosis of pharyngitis. If any other diagnosis exists, the visit will be excluded.</p> <p>4) The patient did not have a new or refill prescription for antibiotics within 30 days prior to the pharyngitis visit date.</p> <p>5) The patient did not have an active prescription for antibiotics as of the pharyngitis visit date. "Active" prescription defined as:                Rx Days Supply &gt;= (URI Visit Date - Prescription Date)</p> <p>6) The patient filled a prescription for antibiotics on or within three days after the pharyngitis visit.</p> <p>If multiple visits exist that meet the above criteria, the first visit will be used.</p> <p><b><u>To be included in the numerator,</u></b> a patient must have received a Group A Streptococcus test within the 7-day period beginning three days prior through three days after the Pharyngitis visit date.</p> <p><b>Patient List:</b> List of patients 2-18 years with pharyngitis and a Group A Strep test, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Colorectal Cancer Screening</b> Epidemiology Program/ Dr. Nathaniel Cobb</p> <p>Same topic as in CRS Selected Measures Report but includes less measures</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> Active Clinical patients ages 51-80 without a documented history of colorectal cancer or total colectomy, broken out by gender.</p> <p><b>Numerators:</b> 1) Patients who have had ANY CRC colorectal screening, defined as any of the following: A) Fecal Occult Blood test (FOBT) during the Report Period; B) flexible sigmoidoscopy or double contrast barium enema in the past five years; C) colonoscopy in the past 10 years, or D) a documented refusal in the past year.</p> <p><b>Definitions:</b> 1) <b>Colorectal Cancer:</b> POV: 153.*, 154.0, 154.1, 197.5, V10.05; <i><b>CPT G0213-G0215, G0231.</b></i></p> <p>2) <b>Total Colectomy:</b> CPT 44150-44151, 44152 (<i>old code</i>), 44153 (<i>old code</i>), 44155-44158 (<i>added codes 44157-44158</i>), 44210-44212; V Procedure 45.8.</p> <p>3) <b>Colorectal Cancer Screening:</b> <i>The most recent of any of the following during applicable timeframes (changed to look at <u>most recent</u> screening):</i></p> <p>A) <b>Fecal Occult Blood lab test (FOBT):</b> CPT 82270, 82274, 89205 (<i>old code</i>), G0107 (<i>old code</i>), <i><b>G0328, G0394; V POV V76.51 Colon screening;</b></i> LOINC taxonomy, or site-populated taxonomy BGP GPRA FOB TESTS</p> <p>B) <b>Flexible Sigmoidoscopy:</b> V Procedure 45.24, 45.42; CPT 45330-45345, G0104</p> <p>C) <b>Double Contrast Barium Enema:</b> CPT or VRad: 74280 (<i>deleted G0106, G0120</i>)</p> <p>D) <b>Colonoscopy:</b> V Procedure 45.22, 45.23, 45.25, 45.43; V POV 76.51; CPT 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, 45325 (<i>old</i>), G0105, G0121</p> <p>E) <b>Screening Refusals:</b> A. <b>FOBT:</b> Refusal of V Lab Fecal Occult Blood test or CPT code 82270, 82274, 89205 (<i>old code</i>), G0107 (<i>old code</i>), <i><b>G0328, or G0394;</b></i> B. <b>Flexible Sigmoidoscopy:</b> Refusal of V Procedure 45.24, 45.42 or CPT 45330-45345, G0104; C. <b>Double Contrast Barium Enema:</b> Refusal of V Radiology CPT: 74280 (<i>deleted G0106, G0120</i>); D. <b>Colonoscopy:</b> Refusal of V Procedure 45.22, 45.23, 45.25, 45.43 or V CPT 44388-44394, 44397, 45355, 45378-45387, 45391, 45392, 45325 (<i>old</i>), G0105, or G0121.</p> <p><b>Patient List:</b> List of patients 51-80 and CRC screening test/date, if any.</p>
<p><b>Breast Cancer Screening (Mammogram)</b> Carolyn Aoyama</p> <p><b>Different from</b> Cancer Screening: Mammogram Rates included in Selected Measures Report</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominators:</b> 1) Female Active Clinical patients ages <i><b>42 (changed from 52)</b></i> through 69, without a documented bilateral mastectomy or two separate unilateral mastectomies. <i><b>Broken down by age groups 42-51 and 52-69.</b></i></p> <p><b>Numerators:</b> All patients who had a Mammogram documented in the past 2 years, including documented refusals in past year.</p> <p><b>Definitions:</b> 1) <b>Bilateral Mastectomy:</b> A) V CPT: <i><b>19300.50-19307.50 OR 19300-19307 w/modifier 09950 (.50 and 09950 modifiers indicate bilateral), or old codes</b></i> 19180, 19200, 19220, or 19240, w/modifier of .50 or 09950 or B) ICD Operation codes: 85.42; 85.44; 85.46; 85.48.</p> <p>2) <b>Unilateral Mastectomy:</b> Requires two separate occurrences for either CPT or procedure codes on 2 different dates of service. A) V CPT: <i><b>19300-19307, or old codes</b></i> 19180, 19200, 19220, 19240 or B) V Procedures: 85.41, 85.43, 85.45, 85.47.</p> <p>3) <b>Mammogram:</b> A) V Radiology or V CPT: <i><b>77052, 77055-77057, 76083 (old code), 76090 (old code), 76091 (old code), 76092 (old code), G0202;</b></i> B) POV: V76.11 Screening mammogram for high risk patient; V76.12 Other screening mammogram; C) V Procedure: 87.36 Xerography of breast, 87.37 Other Mammography; D) Women's Health: Mammogram Screening, Mammogram Dx Bilat, Mammogram Dx Unilat.</p> <p>4) <b>Refusal Mammogram:</b> V Radiology MAMMOGRAM for CPT <i><b>77052, 77055-77057, 76083 (old code), 76090 (old code), 76091 (old code), 76092 (old code) or G0202.</b></i></p> <p><b>Patient List:</b> List of women 42-69 (<i>changed from 52-69</i>) with mammogram/refusal, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Cervical Cancer Screening (Pap Smear)</b> Carolyn Aoyama</p> <p><b>Different from</b> Cancer Screening: Pap Smear Rates included in Selected Measures Report</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> Female Active Clinical patients ages <b>24 (changed from 21)</b> through 64 without documented history of Hysterectomy.</p> <p><b>Numerators:</b> Patients with a Pap Smear documented in the past 3 years, including refusals in past year.</p> <p><b>Definitions:</b> 1) <b>Hysterectomy:</b> Any of the following ever: A) V Procedure: 68.4-68.8 (<i>revised from 68.4-68.9</i>); B) CPT 51925, 56308 (old code), 58150, 58152, 58200-58294, <b>58548</b>, 58550-58554, 58951, 58953-58954, <b>58956</b>, 59135; <i>or C) V POV 618.5.</i></p> <p>2) <b>Pap Smear:</b> A) V Lab: PAP SMEAR; B) POV: <b>V67.01 Follow-up Vaginal Pap Smear</b>, V76.2 Screen Mal Neop-Cervix, V72.31 Routine Gynecological Examination (corrected description), V72.32 Encounter for Pap Cervical Smear to Confirm Findings of Recent Normal Smear Following Initial Abnormal Smear, V72.3 Gynecological Examination , Pap Cervical Smear as Part of General Gynecological Exam, Pelvic Exam (annual) (periodic) (old code, to be counted for visits prior to 10/1/04 only), V76.47 Vaginal Pap Smear for Post-Hysterectomy Patients, (<i>deleted V76.49</i>), or 795.06 Pap smear of cervix with cytologic evidence of malignancy; C) V Procedure: 91.46; D) V CPT: 88141-88167, 88174-88175, <b>G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001</b>, Q0091; E) Women's Health: Procedure called Pap Smear; F) LOINC taxonomy (<i>added one code</i>); G) Site-populated taxonomy BGP GPRA PAP SMEAR; H) Refusal (in past year) Lab Test Pap Smear.</p> <p><b>Patient List:</b> List of women 24-64 (<i>changed from 21-64</i>) with documented test/refusal, if any.</p>
<p><b>Chlamydia Screening in Women</b> Epidemiology Program/ Dr. Jim Cheek, Lori DeRavello, MPH</p> <p>Same as Chlamydia Testing in Selected Measures Report but includes less measures</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> Female Active Clinical patients ages 16 through 25, broken down into age groups 16-20 and 21-25.</p> <p><b>Numerator:</b> Patients tested for Chlamydia during the Report period.</p> <p><b>Definitions: Chlamydia:</b> V73.88, V73.98; CPT: 86631, 86632, 87110, 87270, 87320, 87490-87492, 87810; site-populated taxonomy BGP GPRA CHLAMYDIA TESTS; LOINC taxonomy (<i>deleted from and added several codes to LOINC taxonomy</i>).</p> <p><b>Patient List:</b> List of patients with no documented screening.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Osteoporosis Management in Women Who Had a Fracture</b> Drs. Bruce Finke and Lisa Sumner</p> <p>Same as Osteoporosis Management topic in CRS Selected Measures Report</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> 1) Female Active Clinical patients ages 67 and older who had a new fracture occurring six months (180 days) prior to the Report period through the first six months of the Report period with no osteoporosis screening or treatment in year prior to the fracture.</p> <p><b>Numerator:</b> 1) Patients treated or tested for osteoporosis after the fracture.</p> <p><b>Definitions:</b> 1) <b>Fracture:</b> Does not include fractures of finger, toe, face, or skull. CRS will search for the first (i.e. earliest) fracture during the period six months (180) days prior to the beginning of the Report period and the first six months of the Report period. If multiple fractures are present, only the first fracture will be used.</p> <p>The Index Episode Start Date is the date the fracture was diagnosed. If the fracture was diagnosed at an outpatient visit (Service Category A, S, or O), the Index Episode Start Date is equal to the Visit Date. If diagnosed at an inpatient visit (Service Category H), the Index Episode Start Date is equal to the Discharge Date.</p> <p><b>Fracture codes:</b> A) CPTs: 21800-21825, 22305-22328, <i>22520, 22521, 22523, 22524</i>, 23500-23515, 23570-23630, 23665-23680, 24500-24587, 24620, 24635, 24650-24685, 25500-25609 (<i>added 25606-25609</i>), 25611 (<i>old code</i>), 25620 (<i>old code</i>), 25622-25652, 25680, 25685, 27193-27248, 27254, 27500-27514, 27520-27540, 27750-27828, <i>S2360, S2362</i>; B) POVs: 733.1, 805*-806*, 807.0*-807.4, 808*-815*, 818*-825*, 827*, 828*; C) V Procedure: 79.01-79.03 (<i>deleted 79.00</i>), 79.05-79.07, (<i>deleted 79.09</i>), 79.11-79.13 (<i>deleted 79.10</i>), 79.15-79.17, (<i>deleted 79.19</i>), 79.21-79.23 (<i>deleted 79.20</i>), 79.25-79.27, (<i>deleted 79.29</i>), 79.31-79.33 (<i>deleted 79.30</i>), 79.35-79.37, (<i>deleted 79.39</i>), 79.61-79.63 (<i>deleted 79.60</i>), 79.65-79.67, (<i>deleted 79.69</i>), <i>81.65, 81.66</i>.</p> <p>2) <b>Osteoporosis Treatment and Testing:</b> A) For fractures diagnosed at an outpatient visit: I) A non-discontinued prescription within six months (180 days) of the Index Episode Start Date (i.e. visit date) or II) a BMD test within six months of the Index Episode Start Date. B) For fractures diagnosed at an inpatient visit, a BMD test performed during the inpatient stay.</p> <p>3) <b>BMD Test:</b> A) CPT: <i>77078</i>, 76070 (<i>old code</i>), <i>77079</i>, 76071 (<i>old code</i>), <i>77080</i>, 76075 (<i>old code</i>), <i>77081</i>, 76076 (<i>old code</i>), <i>77083</i>, 76078 (<i>old code</i>), 76977, 78350, 78351, <i>G0130</i>; B) V Procedure 88.98; C) POV V82.81.</p> <p>4) <b>Osteoporosis Treatment Medication:</b> Medication taxonomy BGP HEDIS OSTEOPOROSIS MEDS. (<i>Replaced existing medication taxonomy with updated HEDIS taxonomy.</i>) (Medications are Alendronate, Alendronate-Cholecalciferol, Calcitonin, Estrogen, Ibandronate, Injectable Estrogens, Raloxifene, Risedronate, Teriparatide; <i>removed: Fluoride, Vitamin D, and Calcium Products.</i>)</p> <p><b>Denominator Exclusions:</b></p> <p>1) Patients receiving osteoporosis screening or treatment in the year (365 days) prior to the Index Episode Start Date. Osteoporosis screening or treatment is defined as a Bone Mineral Density (BMD) test (see below for codes) or receiving any osteoporosis therapy medication (see below for codes).</p> <p>2) Patients with a fracture diagnosed at an outpatient visit who ALSO had a fracture within 60 days prior to the Index Episode Start Date.</p> <p>3) Patients with a fracture diagnosed at an inpatient visit who ALSO had a fracture within 60 days prior to the ADMISSION DATE.</p> <p><b>Patient List:</b> List of female patients with new fracture who have had osteoporosis treatment or testing, if any.</p>

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<p><b>Controlling High Blood Pressure</b> Dr. Eric Brody/ Mary Wachacha &amp; Chris Lamer, PharmD</p> <p><b>Different from</b> same topic included in Selected Measures Report</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> Active Clinical patients ages <i>18 (changed from 46)</i> through 85 diagnosed with hypertension and no documented history of ESRD, broken down by <i>age groups of 18-45 and 46-85 and</i> gender.</p> <p><b>Numerator:</b> Patients with adequately controlled blood <i>pressure, defined as &lt;140/90 (changed from &lt;=140/90), i.e. the mean systolic value is less</i> than 140 AND the mean diastolic value is <i>less than</i> 90.</p> <p><b>Definitions:</b> 1) <b>Hypertension:</b> Diagnosis (POV or problem list) 401.* prior to the Report Period, and at least one hypertension POV during the Report Period.</p> <p>2) <b>BP Values (all numerators):</b> Uses mean of last 3 Blood Pressures documented on non-ER visits during the Report Period. If 3 BPs are not available, uses mean of last 2, non-ER BPs. If a visit contains more than 1 BP, the lowest BP will be used, defined as having the lowest systolic value. The mean Systolic value is calculated by adding the last 3 (or 2) systolic values and dividing by 3 (or 2). The mean Diastolic value is calculated by adding the diastolic values from the last 3 (or 2) blood pressures and dividing by 3 (or 2). If the systolic and diastolic values do not BOTH meet the current category, then the value that is least controlled determines the category. <i>For the BP documented numerator only, if CRS is not able to calculate a mean BP, it will search for CPT 3077F or 3080F during the Report Period.</i></p> <p>3) <b>ESRD:</b> Any of the following ever: A) CPT: <i>36145, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90918-90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512, G0257, G0308-G0327, or S9339;</i> B) POV 585.5, 585.6 or V45.1; <i>or C) Procedure 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, or 55.6*.</i></p> <p><b>Patient List:</b> List of patients with hypertension and BP value, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Beta-Blocker Treatment After a Heart Attack</b> Dr. James Galloway/ Mary Wachacha</p> <p>Topic exclusive to HEDIS Report</p>	<p><b>No changes from Version 7.0 Patch 1</b></p> <p><b>Denominator:</b> 1) Active Clinical patients 35 and older discharged for an AMI during the first 51 weeks of the Report period, were not readmitted for any diagnosis within seven days of discharge, and do not have a contraindication/previous adverse reaction to beta-blocker therapy. Broken down by gender.</p> <p><b>Numerator:</b> 1) Patients with active prescription for beta-blockers no later than 7 days after first discharge (i.e. prescribed during stay or at discharge or current at time of admission).</p> <p><b>Definitions:</b> 1) <b>Acute Myocardial Infarction (AMI):</b> POV 410.*1 (i.e. first eligible episode of an AMI) with Service Category H. If patient has more than one episode of AMI during the first 51 weeks of the Report period, CRS will include only the first discharge.</p> <p>2) <b>Beta-blockers:</b> To be included in the numerator, patient must have an active prescription (not discontinued as of [discharge date + 7 days]) either prescribed prior to admission, during the inpatient stay, or within seven days after discharge. "Active" prescription defined as: Days Prescribed &gt; ((Discharge Date + 7 days) - Order Date). Beta blockers defined with Medication taxonomy BGP HEDIS BETA BLOCKER MEDS. (Medications are: Acebutolol HCL, Atenolol, Betaxolol HCL, Bisoprolol fumarate, Carteolol HCL, Carvedilol, Labetalol HCL, Metoprolol succinate, Metoprolol tartrate, Nadolol, Penbutolol sulfate, Pindolol, Propranolol HCL, Sotalol HCL, Timolol maleate.)</p> <p><b>Denominator Exclusions:</b></p> <p>1) Patients with Discharge Type of Irregular (AMA), Transferred, or contains "Death."</p> <p>2) Patients with contraindications to beta-blockers, defined as occurring anytime through discharge date: A) Asthma - 2 diagnoses (POV) of 493* on different visit dates; B) Hypotension - 1 diagnosis of 458*; C) Heart block &gt;1 degree - 1 diagnosis of 426.0, 426.12, 426.13, 426.2, 426.3, 426.4, 426.51, 426.52, 426.53, 426.54, or 426.7; D) Sinus bradycardia - 1 diagnosis of 427.81; or E) COPD - 2 diagnoses on different visit dates of 491.2*, 496, or 506.4, or a combination of any of these codes, such as 1 visit with 491.20 and 1 with 496.</p> <p>3) Documented beta blocker allergy/ADR, defined as occurring anytime through discharge date: A) POV 995.0-995.3 AND E942.0; B) "beta block*" entry in ART (Patient Allergies File); or C) "beta block*", "bblock*" or "b block*" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.</p> <p>4) Patients readmitted for any diagnosis within seven days of discharge.</p> <p><b>Patient List:</b> List of patients with AMI, with beta-blocker prescription, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Persistence of Beta-Blocker Treatment After a Heart Attack</b> Dr. James Galloway/ Mary Wachacha</p> <p>Topic exclusive to HEDIS Report</p>	<p><b>No changes from Version 7.0 Patch 1</b></p> <p><b>Denominator:</b> 1) Active Clinical patients 35 and older diagnosed with an AMI six months prior to the Report period through the first six months of the Report period and do not have a contraindication/previous adverse reaction to beta-blocker therapy. Broken down by gender.</p> <p><b>Numerator:</b> 1) Patients with a 180-day course of treatment with beta-blockers following first discharge date or visit date, including previous active prescriptions.</p> <p><b>Definitions:</b> 1) <b>Acute Myocardial Infarction (AMI):</b> POV 410.*0 or 410.*1, which may be diagnosed at inpatient or outpatient visit.</p> <p>2) <b>Inpatient visit:</b> Service Category of H (Hospitalization) and must occur between six months prior to Report period through first six months of the Report period. If patient has more than one episode of AMI during the timeframe, CRS will include only the first hospital discharge or ambulatory visit.</p> <p>3) <b>Beta-blocker Treatment:</b> To be included in the numerator, patients must have a beta-blocker days' supply <math>\geq 135</math> days in the 180 days following discharge date for inpatient visits or visit date for ambulatory visits. Prior active beta-blocker prescriptions can be included if the treatment days fall within the 180 days following discharge/visit date. Prior active prescription defined as most recent beta-blocker prescription (see codes below) prior to admission/visit date with the number of days supply equal to or greater than the discharge/visit date minus the prescription date.</p> <p><b>NOTE:</b> If the medication was started and then discontinued, CRS will recalculate the # Days Prescribed by subtracting the prescription date (i.e. visit date) from the V Medication Discontinued Date. Example: Rx Date=11/15/2003, Discontinued Date=11/19/2003, Recalculated # Days Prescribed=4.</p> <p>4) <b>Beta-blockers:</b> Medication taxonomy BGP HEDIS BETA BLOCKER MEDS. (Medications are: Acebutolol HCL, Atenolol, Betaxolol HCL, Bisoprolol fumarate, Carteolol HCL, Carvedilol, Labetalol HCL, Metoprolol succinate, Metoprolol tartrate, Nadolol, Penbutolol sulfate, Pindolol, Propranolol HCL, Sotalol HCL, Timolol maleate.)</p> <p>Example of patient included in the numerator who has prior active prescription:</p> <ul style="list-style-type: none"> <li>- Admission Date: 2/1/2004, Discharge Date: 2/15/2004</li> <li>- Must have 135 days prescribed by 8/13/2004 (Discharge Date+180)</li> <li>- Prior Beta-Blocker Rx Date: 1/15/2004</li> <li>- # Days Prescribed: 60 (treats patient through 3/15/2004)</li> <li>- Discharge Date minus Rx Date: 2/15/2004-1/15/2004 = 31,</li> <li>60 is <math>\geq 31</math>, prescription is considered Prior Active Rx</li> <li>- 3/15/2004 is between 2/15 and 8/13/2004, thus remainder of Prior Active Rx can be counted toward 180-day treatment period</li> <li>- # Remaining Days Prescribed from Prior Active Rx: (60-(Discharge Date-Prior Rx Date) = 60-(2/15/2004-1/15/2004) = 60-31 = 29</li> <li>- Rx #2: 4/1/2004, # Days Prescribed: 90</li> <li>- Rx #3: 7/10/2004, #Days Prescribed: 90</li> <li>- Total Days Supply Prescribed between 2/15 and 8/13/2004: 29+90+90=209</li> </ul> <p><b>Denominator Exclusions:</b> 1) If inpatient visit, patients with Discharge Type of Irregular (AMA), Transferred, or contains "Death."</p> <p>2) Patients with contraindications to beta-blockers occurring anytime through discharge/ visit date: A) Asthma - 2 diagnoses (POV) of 493* on different visit dates; B) Hypotension - 1 diagnosis of 458*; C) Heart block <math>&gt;1</math> degree - 1 diagnosis of 426.0, 426.12, 426.13, 426.2, 426.3, 426.4, 426.51, 426.52, 426.53, 426.54, or 426.7; D) Sinus bradycardia - 1 diagnosis of 427.81; or E) COPD - 2 diagnoses on different visit dates of 491.2*, 496, or 506.4, or a combination of any of these diagnoses, such as one visit with 491.20 and one with 496.</p> <p>3) Documented beta blocker allergy/ADR occurring anytime through discharge/visit date: A) POV 995.0-995.3 AND E942.0; B) "beta block*" entry in ART (Patient Allergies File); or C) "beta block*", "bblock*" or "b block*" contained within Problem List or in Provider Narrative field for any POV 995.0-995.3 or V14.8.</p> <p><b>Patient List:</b> List of patients with AMI, with all beta-blocker prescriptions during the 180-day timeframe, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Cholesterol Management for Patients with Cardiovascular Conditions</b> Dr. Eric Brody/ Mary Wachacha &amp; Chris Lamer, PharmD</p> <p><b>Different from</b> same topic included in Selected Measures Report</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> Active Clinical patients ages 18 to 75 who, during the first 10 months of the year prior to the beginning of the Report period, were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), OR who were diagnosed with ischemic vascular disease (IVD) <i>during the Report Period and the year prior to the Report Period (changed timeframe for IVD)</i>. Broken down by gender.</p> <p><b>Numerators:</b> 1) Patients with LDL completed during the Report Period, regardless of result.  2) <i>Patients with LDL &lt;100 (changed from &lt;=100), completed during the Report Period.</i>  <i>DELETED: Patients with LDL 101-130, completed during the Report Period.</i>  <i>DELETED: Patients with LDL &gt;130, completed during the Report Period.</i></p> <p><b>Definitions:</b> 1) <b>AMI:</b> POV 410.*0 or 410.*1.  2) <b>PTCA:</b> A) V Procedure <i>00.66</i>, 36.01 (<i>old code</i>), 36.02 (<i>old code</i>), 36.05 (<i>old code</i>), <i>36.06-36.07</i>, 36.09 or B) CPT 33140, 92980-92982, 92984, 92995, 92996.  3) <b>CABG:</b> A) V Procedure 36.1*, 36.2 or B) CPT 33510-33514, 33516-33519, 33521-33523, 33533-33536, 35600, 33572, <i>S2205-S2209</i>. If diagnosis occurred at an inpatient visit, discharge date will be used instead of visit date.  4) <b>IVD:</b> (<i>Deleted all of the different categories within IVD (e.g. stable angina, stroke) and lumped all under IVD.</i>) POV 411.*, 413.*, 414.0*, <i>414.8, 414.9</i>, 429.2, 433.*-434.*, 440.1, 440.2*, 444.*, or 445.*. (<i>Deleted 435.*, 437.0, 437.1, 438.0-438.42, 438.5*, 438.6-438.9, 441.*, and 443.9.</i>)  5) <b>LDL:</b> Searches for most recent LDL test with a result during the Report Period. If none found, CRS searches for the most recent LDL test without a result. CPT <i>80061, 83700, 83701, 83704, 83715 (old code), 83716 (old code)</i>, 83721, <i>3048F, 3049F, 3050F</i>; LOINC taxonomy (<i>added to and removed code from LOINC taxonomy</i>); site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX. For numerator LDL &lt;100, CPT 3048F will count as meeting the measure.</p> <p><b>Patient List:</b> List of patients with AMI, CABG, PTCA, or IVD w/LDL value, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Comprehensive Diabetes Care</b> Diabetes Program/ Dr. Charlton Wilson</p> <p><b>Different from</b> Diabetes Comprehensive Care topic in Selected Measures Report</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> 1) Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes prior to the Report period, AND at least 2 visits during the Report period, AND 2 DM-related visits ever.</p> <p><b>Numerators:</b> 1) <b>A1c Tested:</b> Number of patients with a Hemoglobin A1c documented during the Report period, regardless of result.</p> <p>2) <b>Poor Glycemic Control:</b> Patients with A1c greater than (&gt;) 9.0 or patients with no test or a test with no value.</p> <p>3) <i><b>Good Glycemic Control: Patients with A1c less than (&lt;) 7.0.</b></i></p> <p>4) <b>Eye Exam Performed:</b> Patients receiving a qualified retinal evaluation during the Report Period, or a documented refusal of a diabetic retinal exam.</p> <p>5) <b>LDL Screening:</b> Patients with LDL completed during the Report period, regardless of result.</p> <p><i><b>DELETED: 6) Controlled LDL: Patients with LDL results less than (&lt;) 130.</b></i></p> <p>6) <i><b>LDL &lt;100:</b></i> Patients with LDL results <i>less than (&lt;) 100 (renamed numerator and changed LDL value from &lt;=100).</i></p> <p>7) <i><b>Medical Attention for Nephropathy (renamed from Kidney Disease Monitored):</b></i> Patients who have received nephropathy screening, defined as patients who have had <i>a non-null microalbuminuria test result during the Report Period OR have evidence of nephropathy (changed from a positive urine protein test or any non-null microalbuminuria test result during the Report period).</i></p> <p><i><b>DELETED as separate numerator (combined with #7 above): 8) Kidney Disease Monitored: Patients who have evidence of nephropathy.</b></i></p> <p>8) <i><b>Blood Pressure Level &lt; 130/80: Patients with BP level of &lt; 130/80 during the Report Period.</b></i></p> <p>9) <i><b>Blood Pressure Level &lt; 140/90: Patients with BP level of &lt; 140/90 during the Report Period.</b></i></p> <p><i><b>DELETED: 9) Comprehensive Care: Patients who had all of the following: A1c tested AND eye exam performed AND LDL screening performed AND nephropathy assessment (i.e. nephropathy screening or evidence of nephropathy).</b></i></p> <p><b>Definitions:</b> 1) <b>Diabetes:</b> First Purpose of Visit 250.00-250.93 recorded in the V POV file prior to the Report period.</p> <p>2) <b>A1c:</b> Searches for most recent A1c test with a result during the Report Period. If none found, CRS searches for the most recent A1c test without a result. A1c defined as any of the following: CPT 83036, <i>83037, 3046F, or 3047F</i>; LOINC taxonomy <i>(added code to taxonomy)</i> or site-populated taxonomy DM AUDIT HGB A1C TAX. <i>A1c tests documented with CPT 3046F indicate a result &gt; 9.0 and will be included in the Poor Control numerator.</i></p> <p>3) <b>Qualified Retinal Evaluation*:</b> A) diabetic retinal exam or documented refusal or B) other eye exam.</p> <p>A) <b>Diabetic Retinal Exam:</b> Any of the following during the Report Period: 1) Exam Code 03 Diabetic Eye Exam (dilated retinal examination) or Refusal of Exam 03 <i>or 2) CPT 2022F Dilated retinal eye exam; 2024F Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist; 2026F Eye imaging validated to match the diagnosis from seven standard field stereoscopic photos; S0620 Routine ophthalmological examination including refraction; new patient; S0621 Routine ophthalmological examination including refraction; established patient; S3000 Diabetic indicator; retinal eye exam, dilated, bilateral.</i></p>

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<b>Comprehensive Diabetes Care (cont'd)</b> Diabetes Program/ Dr. Charlton Wilson	<p><b>B) Other Eye Exam:</b> (1) Non-DNKA (did not keep appointment) visits to ophthalmology, optometry, or validated tele-ophthalmology retinal evaluation clinics (e.g. JVN, Inoveon, EyeTel, etc.) or (2) non-DNKA visits to an optometrist or ophthalmologist. Searches for the following codes in the following order: Clinic Codes A2, 17, 18, 64; Provider Code 24, 79, 08; CPT <b>67028, 67038, 67039, 67040</b>, 67101, 67105, 67107, 67108, 67110, 67112, 67141, 67145, 67208, 67210, 67218, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260 (<i>deleted 92287</i>); Procedure Codes 14.1*-14.5*, 14.9*, 95.02-95.04 (<b>added 95.02</b>), 95.11, 95.12, 95.16; POV V72.0.</p> <p>*Qualifying retinal evaluation: The following methods are qualifying for this measure:</p> <ul style="list-style-type: none"> <li>- Dilated retinal evaluation by an optometrist or ophthalmologist.</li> <li>- Standard fields stereoscopic photos (ETDRS) evaluated by an optometrist or ophthalmologist.</li> <li>- Any photographic method formally validated to ETDRS, e.g. JVN, Inoveon, EyeTel, etc.</li> </ul> <p>4) <b>LDL Screening:</b> Searches for most recent LDL test with a result during the Report Period. If none found, CRS searches for the most recent LDL test without a result. LDL defined as: <b>CPT 80061, 83700, 83701, 83704, 83715 (old code), 83716 (old code), 83721, 3048F, 3049F, 3050F</b>; LOINC taxonomy (<b>added to and removed code from LOINC taxonomy</b>); site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX. <b>For numerator LDL &lt;100, CPT 3048F will count as meeting the measure.</b></p> <p>5) <b>Medical Attention for Nephropathy:</b> Patient must meet at least one of the two conditions below:</p> <p>A) <b>Nephropathy Screening:</b> CRS searches during the Report Period for the last microalbuminuria lab test <b>with a result</b>, using the 1) LOINC taxonomy or 2) site-populated taxonomy DM AUDIT MICROALBUMINURIA TAX or DM AUDIT A/C RATIO taxonomy or any of the following microalbuminuria CPT codes <b>without a result (since results are not recorded in RPMS): 82042, 82043, 82044, (deleted 83518, and 84166/81050), 84156, 3060F, or 3061F, OR</b></p> <p>B) <b>Evidence of Nephropathy:</b> Any of the following during the Report Period:</p> <p>1) Urine protein (urine macroalbumin) test with positive value. Positive value for urine protein is defined as any of the following:</p> <ul style="list-style-type: none"> <li>- First character of result is "P", "p", "M", "m", "L", "l", "S", or "s"</li> <li>- Value contains a "+" sign</li> <li>- Value contains a "&gt;" symbol</li> <li>- Value is a number greater than 29</li> </ul> <p>Urine protein defined as any of the following: <b>CPT 3062F</b>; LOINC taxonomy; site-populated taxonomy DM AUDIT URINE PROTEIN TAX.</p> <p>2) Evidence of treatment for nephropathy, defined as any of the following:</p> <ul style="list-style-type: none"> <li>- <b>V CPT:</b> <b>36145</b>, 36800, 36810, 36815, 36818, 36819, 36820, 36821, <b>36831-36833</b>, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, <b>90939, 90940</b>, 90945, 90947, 90989, 90993, 90997, 90999, 99512, <b>3066F, G0257, G0314-G0319, G0322, G0323, G0326, G0327, S9339.</b></li> <li>- <b>V POV:</b> 250.4, 403*, 404*, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584*-586*, 588*, 753.0, 753.1, 791.0, V42.0, V45.1, V56.</li> <li>- <b>V Procedure:</b> <b>38.95</b>, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6.</li> <li>- <b>Nephrologist visit</b>, defined as: Clinic Code 49 or Provider Code 64.</li> </ul> <p>3) <b>Prescription for ACE Inhibitor/ARB therapy with days supply &gt; 0 during the Report Period. Ace Inhibitor (ACEI) medication codes defined with CPT 4009F or medication taxonomy BGP HEDIS ACEI MEDS. ACEI medications: Benazepril (Lotensin), Captopril (Capoten), Enalapril (Vasotec), Fosinopril (Monopril), Lisinopril (Prinivil Zestril), Moexipril (Univasc), Perindopril (Aceaon), Quinapril (Accupril), Ramipril (Altace), Trandolopril (Mavik).</b></p>

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<b>Comprehensive Diabetes Care (cont'd)</b> Diabetes Program/ Dr. Charlton Wilson	<p><i><b>ACEI-Combination Products: Amlodipine-benazepril (Lotrel), Benazepril + HCTZ (Lotensin HCT), Captopril + HCTZ (Capozide, Hydrochlorothiazide + Capropril), Enalapril + HCTZ (Vaseretic), Enalapril-felodipine (Lexxel), Enalapril-diltiazem (Teczem), Fosinopril + HCTZ (Monopril HCT), Lisinopril + HCTZ (Prinzide, Zestoreti, Hydrochlorothiazide + Lisinopril), Moexipril + HCTZ (Uniretic), Quinapril + HCTZ (Accuretic, Quinaretic).</b></i></p> <p><i><b>ARB (Angiotensin Receptor Blocker) medication codes defined with medication taxonomy BGP HEDIS ARB MEDS. ARB medications: Candesartan (Atacand), Eprosartan (Teveten), Irbesartan (Avapro), Losartan (Cozaar), Olmesartan (Benicar), Telmisartan (Micardis), Valsartan (Diovan).</b></i></p> <p><i><b>ARB Combination Products: Candesartan + HCTZ (Atacand HCT), Eprosartan + HCTZ (Teveten HCT), Irbesartan + HCTZ (Avalide HCT), Losartan + HCTZ (Hyzaar HCT), Olmesartan + HCTZ (Benicar HCT), Telmisartan + HCTZ (Micardis HCT), Valsartan (Diovan HCT).</b></i></p> <p><b>Patient List:</b> List of diabetic patients w/documenteds tests, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Use of Appropriate Medications for People with Asthma</b> Drs. Charles (Ty) Reidhead and Charles North</p> <p>Same topic as Asthma Quality of Care in Selected Measures Report</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> Active Clinical patients ages 5-56 with persistent asthma within the year prior to the beginning of the Report period and during the Report period, without a documented history of emphysema or chronic obstructive pulmonary disease (COPD), broken down by age groups.</p> <p><b>Numerator:</b> Patients who had at least one dispensed prescription for primary asthma therapy medication during the Report period.</p> <p><b>Definitions:</b> 1) <b>Emphysema:</b> Any visit at any time on or before the end of the Report period with POV codes: 492.*, 506.4, 518.1, 518.2.</p> <p>2) <b>Chronic obstructive pulmonary disease (COPD):</b> Any visit at any time on or before the end of the Report period with POV codes: 491.20, 491.21, 491.22, <i>493.2*</i>, 496, 506.4 (<i>revised range from 506.* to 506.4</i>).</p> <p>3) <b>Persistent Asthma:</b> Any of the following four criteria below within the year prior to the beginning of the Report period AND during the Report period:</p> <p>A) At least one visit to Clinic Code 30 (Emergency Medicine) with primary diagnosis 493* (asthma).</p> <p>B) At least one acute inpatient discharge with primary diagnosis 493.*. Acute inpatient discharge defined as Service Category of H.</p> <p>C) At least four outpatient visits, defined as Service Categories A, S, or O, with primary or secondary diagnosis of 493.* AND at least two asthma medication dispensing events (see definition below).</p> <p>D) At least 4 asthma medication dispensing events (see definition below). If the sole medication was leukotriene modifiers, then MUST also meet criteria in 1-3 above or have at least one visit with POV 493.* in the same year as the leukotriene modifier (i.e. during the Report period or within the year prior to the beginning of the Report period.).</p> <p>OR meeting the criteria below:</p> <p>E) Categorized in the Asthma Register System (ARS) at ANY time before the end of the Report period as Active patient with Severity 2, 3 or 4.</p> <p><b>Dispensing Event:</b> One prescription of an amount lasting 30 days or less. For RXs longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day RX is equal to three dispensing events (<math>100/30 = 3.33</math>, rounded down to 3). Also, two different RXs dispensed on the same day are counted as two different dispensing events. Inhalers should also be counted as one dispensing event.</p> <p><b>NOTE:</b> If the medication was started and then discontinued, CRS will recalculate the # Days Prescribed by subtracting the prescription date (i.e. visit date) from the V Medication Discontinued Date. Example: Rx Date=11/15/2003, Discontinued Date=11/19/2003, Recalculated # Days Prescribed=4.</p> <p><b>Asthma medication codes for denominator</b> defined with medication taxonomies: BGP HEDIS ASTHMA MEDS, BGP HEDIS ASTHMA LEUK MEDS, BGP HEDIS ASTHMA INHALED MEDS. (Medications are: Inhaled Corticosteroids, Nedocromil, Cromolyn Sodium, Leukotriene Modifiers, Methylxanthines, Long-acting, inhaled beta-2 agonists, or <i>Short-acting, inhaled beta-2 agonists.</i>)</p> <p>4) <b>Primary Asthma Therapy:</b> To be included in the numerator, patient must have a non-discontinued prescription for primary asthma therapy (see list of medications below) during the Report period.</p> <p><b>Primary asthma therapy medication codes for numerator</b> defined with medication taxonomy: BGP HEDIS PRIMARY ASTHMA MEDS. (<i>Replaced existing medication taxonomy with updated HEDIS taxonomy.</i>) (Medications are: Inhaled Corticosteroids, Nedocromil, Cromolyn Sodium, Leukotriene Modifiers or Methylxanthines.)</p> <p><b>Patient List:</b> Asthmatic patients with primary asthma therapy medications, if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Antidepressant Medication Management</b> Denise Grenier, LCSW/ Dr. David Sprenger</p> <p>Same topic as in CRS Selected Measures Report</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> As of the 120th day of the Report period, Active Clinical patients 18 years and older who were diagnosed with a new episode of depression and treated with antidepressant medication in the past year.</p> <p><b>Numerators:</b> 1) <u>Optimal Practitioner Contacts:</u> Patients with at least three mental health visits with a non-mental health or mental health provider within 12 weeks (84 days) after diagnosis, two of which must be face-to-face visits and one of which must be with a prescribing provider.</p> <p>2) <u>Effective Acute Phase Treatment:</u> Patients who filled a sufficient number of separate prescriptions/refills of antidepressant medication for continuous treatment of at least 84 days (12 weeks).</p> <p>3) <u>Effective Continuation Phase Treatment:</u> Patients who filled a sufficient number of separate prescriptions/refills of antidepressant medication treatment to provide continuous treatment for at least 180 days (6 months).</p> <p><b>Definitions:</b> 1) <b>Major Depression:</b> POV 296.2*, 296.3*, 298.0, 300.4, 309.1, 311.</p> <p>2) <b>Antidepressant Medications:</b> Medication taxonomy BGP HEDIS ANTIDEPRESSANT MEDS. (<i>Replaced existing medication taxonomy with updated HEDIS taxonomy.</i>) (Medications are: Tricyclic antidepressants (TCA) and other cyclic antidepressants, Selective serotonin reuptake inhibitors (SSRI), Monoamine oxidase inhibitors (MAOI), Serotonin-norepinephrine reuptake inhibitors (SNRI), and other antidepressants.)</p> <p>3) <b>Index Episode Start Date:</b> The date of the patient's earliest visit during this period. For inpatient visits, the discharge date will be used.</p> <p><b><u>To be included in the denominator, patient must meet BOTH of the following conditions:</u></b></p> <p>1) One of the following from the 121st day of the year prior to the Report period to the 120th day of the Report period: 1) one visit in any setting with major depression DX (see list of codes) as primary POV, 2) two outpatients visits occurring on different dates of service with secondary POV of major depression, or 3) an inpatient visit with secondary POV of major depression.</p> <p>For example, if Report period is July 1, 2005 - June 30, 2006, patient must have one of the three scenarios above during 11/1/2004 - 10/29/2005.</p> <p>2) Filled a prescription for an antidepressant medication (see list of medications below) within 30 days before the Index Episode Start Date or 14 days on or after that date. In V Medication, Date Discontinued must not be equal to the prescription (i.e. visit) date. The Index Prescription Date is the date of earliest prescription for antidepressant medication filled during that time period.</p> <p><b><u>Denominator Exclusions:</u></b></p> <p>1) Patients who have had any diagnosis of depression within the previous 120 days (4 months) of the Index Episode Start Date. The POVs to be checked for prior depressive episodes is more comprehensive and include the following: POV 296.2*-296.9*, 298.0, 300.4, 309.0, 309.1, 309.28, 311, or</p> <p>2) Patients who had a new or refill prescription for antidepressant medication (see list of medications below) within 90 days (3 months) prior to the Index Prescription Date are excluded as they do not represent new treatment episodes, or</p> <p>3) Patients who had an acute mental health or substance abuse inpatient stay during the 245 days after the Index Episode Start Date treatment period. Acute mental health stays are defined as Service Category of H and primary POV 290*, 293*-302*, 306*-316*. Substance abuse inpatient stays are defined as Service Category of H and primary POV 291*-292*, 303*-305* or primary POV 960*-979* AND secondary POV of 291*-292*, 303*-305*.</p> <p><b><u>Optimal Practitioner Contacts numerator, patient must have one of the following:</u></b></p> <p>1) Three face-to-face follow-up outpatient, non-ER visits (clinic code not equal to 30) or intermediate treatment with either a non-mental health or mental health provider within 84 days after the Index Episode Start Date, or</p>

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<b>Antidepressant Medication Management (cont'd)</b> Denise Grenier, LCSW/ Dr. David Sprenger	<p>2) Two face-to-face outpatient, non-ER visits (clinic code not equal to 30) and one telephone visit (Service Category T) with either a non-mental health or mental health provider within 84 days after the Index Episode Start Date. For either option, one of the visits must be to a prescribing provider, defined as provider codes 00, 08, 11, 16-18, 21, 24-25, 30, 33, 41, 44-45, 47, 49, 64, 67-68, 70-83, 85-86, A1, A9, or B1-B6. NOTE: If patient was diagnosed with two secondary diagnoses of depression, the second visit may be counted toward the numerator.</p> <p><b>Outpatient mental health provider visits are defined as BHS or PCC visit with primary provider code of 06, 12, 19, 48, 49, 50, 62, 63, 81, or 92-96, AND</b></p> <ol style="list-style-type: none"> <li>1. A) Service category A, S, or O, and B1) CPT 90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871 (<i>old code</i>), 90875, 90876, 99384-99387, 99394-99397, 99401-99404, <i>G0155, G0176, G0177, H0002, H0004, H0331, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485</i> or B2) POV 290*, 293*-302*, 306*-316*, OR</li> <li>2. A) Service category of A, S, or O and B1) Location of Encounter = Home (as designated in Site Parameters) or B2) clinic code = 11, OR</li> <li>3. Service category of T.</li> </ol> <p><b>Outpatient <u>non</u>-mental health provider visits are defined as BHS or PCC visits with:</b></p> <ol style="list-style-type: none"> <li>1. A) Service category A, S, or O, and B) CPT 90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871 (<i>old code</i>), 90875, 90876, <i>G0155, G0176, G0177, H0002, H0004, H0331, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485</i>, OR</li> <li>2. A1) Service category A, S, O, or T or A2) Location of Encounter = Home (as designated in Site Parameters) or A3) clinic code 11 and B) POV 290*, 293*-302*, 306*-316*, OR</li> <li>3. A) Service category A, S, or O, and B) CPT 99384-99387, 99394-99397, 99401-99404 and C) POV 290*, 293*-302*, 306*-316*.</li> </ol> <p><b>Effective Acute Phase Treatment numerator:</b> For all antidepressant medication prescriptions filled (see list of medications below) within 114 days of the Index Prescription Date, from V Medication CRS counts the days prescribed (i.e. treatment days) from the Index Prescription Date until a total of 84 treatment days has been established. If the patient had a total gap exceeding 30 days or if the patient does not have 84 treatment days within the 114 day timeframe, the patient is not included in the numerator.</p> <p><b>NOTE:</b> If the medication was started and then discontinued, CRS will recalculate the # Days Prescribed by subtracting the prescription date (i.e. visit date) from the V Medication Discontinued Date. Example: Rx Date=11/15/2004, Discontinued Date=11/19/2004, Recalculated # Days Prescribed=4.</p> <p><b>Example of Patient Included in Numerator:</b></p> <ul style="list-style-type: none"> <li>- 1st RX is Index Rx Date: 11/1/2004, # Days Prescribed=30 Rx covers patient through 12/1/2004</li> <li>- 2nd RX: 12/15/2004, # Days Prescribed=30 Gap #1 = (12/15/2004-12/1/2004) = 14 days Rx covers patient through 1/14/2005</li> <li>- 3rd RX: 1/10/2005, # Days Prescribed=30 No gap days. Rx covers patient through 2/13/2005</li> <li>- Index Rx Date 11/1/2004 + 114 days = 2/23/2005</li> <li>- Patient's 84th treatment day occurs on 2/7/2005, which is ≤ 2/23/2005 AND # gap days of 14 is less than 30.</li> </ul>

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<b>Antidepressant Medication Management (cont'd)</b> Denise Grenier, LCSW/ Dr. David Sprenger	<p><b><u>Example of Patient Not Included in Numerator:</u></b></p> <ul style="list-style-type: none"> <li>- 1st Rx is Index Rx Date: 11/1/2004, # Days Prescribed=30 Rx covers patient through 12/1/2004</li> <li>- 2nd Rx: 12/15/2004, # Days Prescribed=30 Gap #1 = (12/15/2004-12/1/2004) = 14 days Rx covers patient through 1/14/2005</li> <li>- 3rd Rx: 2/01/2005, # Days Prescribed=30 Gap #2 = (2/01/2005-1/14/2005) = 18, total # gap days = 32, so patient is not included in the numerator.</li> </ul> <p><b><u>Effective Continuation Phase Treatment numerator:</u></b> For all antidepressant medication prescriptions (see list of medications below) filled within 231 days of the Index Prescription Date, CRS counts the days prescribed (i.e. treatment days) (from V Medication) from the Index Prescription Date until a total of 180 treatment days has been established. If the patient had a total gap exceeding 51 days or if the patient does not have 180 treatment days within the 231 day timeframe, the patient is not included in the numerator.</p> <p>NOTE: If the medication was started and then discontinued, CRS will recalculate the # Days Prescribed by subtracting the prescription date (i.e. visit date) from the V Medication Discontinued Date. Example: Rx Date=11/15/2004, Discontinued Date=11/19/2004, Recalculated # Days Prescribed=4.</p> <p><b>Patient List:</b> List of patients with new depression DX and optimal practitioner contact (OPC), acute phase treatment (APT) and continuation phase treatment (CONPT), if any.</p>

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Drugs to be Avoided in the Elderly</b> Dr. Bruce Finke</p> <p>Same topic as in CRS Selected Measures Report</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> Active Clinical patients ages 65 and older, broken down by gender.</p> <p><b>Numerators:</b> 1) Patients who received at least one drug to be avoided in the elderly during the Report Period. 2) Patients who received at least two different drugs to be avoided in the elderly during the Report Period.</p> <p><b>Definitions:</b> 1) <b>Drugs to be Avoided in the Elderly (i.e. potentially harmful drugs):</b> Defined with medication taxonomies: (<i>Replaced all existing medication taxonomies with updated HEDIS taxonomies.</i>)</p> <p>A) BGP HEDIS ANTIANXIETY MEDS (Meprobamate [Equagesic, Equanil, Miltown])</p> <p>B) BGP HEDIS ANTIEMETIC MEDS (Trimethobenzamide [Tigan])</p> <p>C) BGP HEDIS ANALGESIC MEDS (Ketorolac [Tordal])</p> <p>D) BGP HEDIS ANTIHISTAMINE MEDS (Cyproheptadine [Periactin], Dexchlorpheniramine [Polaramine], Diphenhydramine [Benadryl], <i>Ephedrine</i>, Hydroxyzine [Vistaril, Atarax], Promethazine [Phenergan], <i>Theophylline</i>, Tripeleennamine)</p> <p>E) BGP HEDIS ANTIPSYCHOTIC MEDS (Thioridazine [Mellaril])</p> <p>F) BGP HEDIS AMPHETAMINE MEDS (Amphetamine Mixtures [Adderall], Benzphetamine [Didrex], Dextroamphetamine [Dexedrine], <i>Dexmethylphenidate</i>, Diethylpropion [Tenuate], Methamphetamine [Desoxyn], Methylphenidate [e.g. Ritalin, Methylin], (<i>deleted Pemoline (Cyclert)</i>), Phendimetrazine [Prelu-2], Phenteramine [Ionamin, Adipex])</p> <p>G) BGP HEDIS BARBITUATE MEDS (Amobarbital/Secobarbital [Tuinal], <i>Amytal</i>, Aprobarbital [Alurate], Butabarbital [Butisol], Mephobarbital [Mebaral], Pentobarbital [Nembutal], Phenobarbital, Secobarbital [Seconal])</p> <p>H) BGP HEDIS BENZODIAZEPINE MEDS (Chlordiazepoxide [Librium], Chlordiazepoxide/Amitriptyline [Limbitrol], Diazepam [Valium], Flurazepam [Dalmane])</p> <p>I) BGP HEDIS OTHER BENZODIAZEPINE (Clidinium/Chlordiazepoxide [Librax])</p> <p>J) BGP HEDIS CALCIUM CHANNEL MEDS (Nifedipine [Procardia, Adalat] - short acting only)</p> <p>K) BGP HEDIS GASTRO ANTISPASM MEDS (Dicyclomine [Bentyl], Propantheline [Pro-Banthine])</p> <p>L) BGP HEDIS BELLADONNA ALKA MEDS (Atropine sulfate, Belladonna, Hyoscyamine [Anaspaz, Cystospaz, Levsin, Levsinex], In combination [Barbidonna, Bellergal-S, Butibel, Donnatal], Scopolamine [Scopace, Transderm-Scope])</p> <p>M) BGP HEDIS SKEL MUSCLE RELAX MED (Carisoprodol [Soma], Chlorzoxazone [Paraflex], Cyclobenzaprine [Flexeril], Metaxalone [Skelaxin], Methocarbamol [Robaxin], Orphenadrine [Norflex])</p> <p>N) BGP HEDIS ORAL ESTROGEN MEDS (<i>Estradiol, Ethinyl estradiol</i>, Premarin, Ogen, Menest)</p> <p>O) BGP HEDIS ORAL HYPOGLYCEMIC MED (Chlorpropamide [Diabinese])</p> <p>P) BGP HEDIS NARCOTIC MEDS (Meperidine, Pentazocine [Talacen, Talwin, Talwin Cpd, Talwin NX], Propoxyphene combinations [Darvon CPD, Darvon N, Darvocet-N], Propoxyphene [Darvon])</p> <p>Q) BGP HEDIS VASODILATOR MEDS (<i>deleted Cyclandelate (Cyclospasmol)</i>, Dipyridamole [Persantine] short acting only, Ergot mesyloids [Hydergine], Isoxsuprine [Vasodilan])</p> <p>R) BGP HEDIS OTHER MEDS AVOID ELD (<i>Atropine injectable, Cyclandelate</i>, Desiccated thyroid, <i>Diazepam injectable, Dicyclomine injectable, Diphenhydramine injectable, Dipyridamole injectable, Hydroxyzine injectable, Ketorolac injectable, Meperidine injectable, Methocarbamol injectable, Mesoridazine</i>, Methyltestosterone [Android, Virilon, Testrad], Nitrofurantoin [Macrochantin], <i>Orphenadrine injectable, Pemoline, Pentazocine, Pentobarbital, Promethazine, Premarin injectable, Rectal Diastat, Scopolamine injectable, patches, Trimethobenzamide</i>)</p>

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<b>Drugs to be Avoided in the Elderly (Cont'd)</b> Dr. Bruce Finke	For each medication, the days supply must be >0. If the medication was started and then discontinued, CRS will recalculate the # Days Prescribed by subtracting the prescription date (i.e. visit date) from the V Medication Discontinued Date. Example: Rx Date=11/15/2006, Discontinued Date=11/19/2006, Recalculated # Days Prescribed=4. <b>Patient List:</b> List of patients 65 and older with at least one prescription for a potentially harmful drug.
<b>Medical Assistance with Smoking Cessation</b> Mary Wachacha/Epidemiology Program, Dr. Nat Cobb  <u><b>Different from</b></u> Tobacco Cessation included in Selected Measures Report	<i><b>Changes from Version 7.0 Patch 1, as noted below.</b></i> <b>Denominator:</b> 1) Active Clinical patients identified as current tobacco users prior to the Report Period. <b>Numerators:</b> 1) Patients who have received tobacco cessation counseling during the Report Period, including documented refusal in past year. 2) Patients counseled during the Report period on smoking cessation medications, including documented refusal in past year. <b>Definitions:</b> 1) <b>Current Tobacco Users:</b> A) Health Factors: Current Smoker, Current Smokeless, Current Smoker and Smokeless, Cessation-Smoker, Cessation-Smokeless; B) Tobacco-related Diagnoses (POV or active Problem List): 305.1, 305.10-305.12 (old codes), or 649.00-649.04 ( <i>deleted V15.82</i> ); C) Dental code 1320; <i><b>D) CPT 1034F or 1035F.</b></i> 2) <b>Tobacco Cessation Counseling:</b> Any of the following during the Report Period: A) Patient Education codes containing "TO-", "-TO", or "-SHS" except for code "TO-M" (reported in separate numerator), <i><b>305.1, 305.1* (old codes), or 649.00-649.04;</b></i> B) Clinic Code 94 (tobacco cessation clinic); C) Dental Code 1320; D) CPT code G0375, G0376, <i><b>or 4000F;</b></i> E) <i><b>Prescription for tobacco cessation aid, defined as any of the following: 1. Medication in the site-populated BGP CMS SMOKING CESSATION MEDS taxonomy; 2. Any medication with name containing "NICOTINE PATCH", "NICOTINE POLACRILEX", "NICOTINE INHALER", or "NICOTINE NASAL SPRAY"; 3. CPT 4001F;</b></i> F) Documented refusal of patient education codes containing "TO-", "-TO", or "-SHS" except for refusal of code "TO-M" (reported in separate numerator). 3) <b>Tobacco Cessation Medication Counseling:</b> Patient education code TO-M or documented refusal during Report period of code TO-M. <b>Patient List:</b> List of tobacco users with tobacco cessation intervention, if any.
<b>Flu Shots for Adults Ages 50-64</b> Epidemiology Program/ Amy Groom, MPH  Same as Adult Immunizations: Influenza in CRS Selected Measures Report but includes less measures	<i><b>Changes from Version 7.0 Patch 1, as noted below.</b></i> <b>Denominator:</b> 1) All Active Clinical patients ages 50-64. <b>Numerator:</b> 1) Patients with influenza vaccine or refusal documented during the Report Period <i><b>or with a contraindication documented at any time before the end of the Report Period.</b></i> <b>Definitions:</b> 1) <b>Influenza Vaccine/Contraindication/Refusal:</b> Any of the following documented during the Report Period unless otherwise noted: A) <b>Influenza Immunization:</b> 1) Immunization/CVX codes 15, 16, 88, or 111; 2) POV V04.8 (old code), V04.81, V06.6; 3) CPT 90655, 90656, 90657-90660, 90724 ( <i>old code</i> ), <i><b>G0008, G8108;</b></i> 4) ICD Procedure 99.52. <i><b>B) Contraindication: Documented at any time before the end of the Report Period, defined as: 1) Contraindication in the Immunization Package of "Egg Allergy" or "Anaphylaxis" or 2) PCC NMI Refusal.</b></i> C) <b>Refusal:</b> Refusal of immunization codes 88, 111, 15, or 16, as documented in PCC Refusal File (i.e. REF) or in the Immunization Package as contraindication of "Patient Refusal." <b>Patient List:</b> List of patients ages 50-64 w/ IZ code/date, if any.

Performance Measure Topic Name and Owner/Contact	General Definition (NOTE: <i>Red, bold italic type</i> indicates new or edited definitions)
<p><b>Flu Shots for Older Adults</b> Epidemiology Program/ Amy Groom, MPH</p> <p>Same as Adult Immunizations: Influenza in CRS Selected Measures Report but includes less measures</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> 1) All Active Clinical patients ages 65 or older.</p> <p><b>Numerator:</b> 1) Patients with influenza vaccine or refusal documented during the Report Period <i>or with a contraindication documented at any time before the end of the Report Period.</i></p> <p><b>Definitions:</b> 1) <b>Influenza Vaccine/Contraindication/Refusal:</b> Any of the following documented during the Report Period unless otherwise noted:</p> <p>A) <b>Influenza Immunization:</b> 1) Immunization/CVX codes 15, 16, 88, or 111; 2) POV V04.8 (old code), V04.81, V06.6; 3) CPT 90655, 90656, 90657-90660, 90724 (<i>old code</i>), <i>G0008, G8108</i>; 4) ICD Procedure 99.52.</p> <p><i>B) Contraindication: Documented at any time before the end of the Report Period, defined as: 1) Contraindication in the Immunization Package of "Egg Allergy" or "Anaphylaxis" or 2) PCC NMI Refusal.</i></p> <p>C) <b>Refusal:</b> Refusal of immunization codes 88, 111, 15, or 16, as documented in PCC Refusal File (i.e. REF) or in the Immunization Package as contraindication of "Patient Refusal."</p> <p><b>Patient List:</b> List of patients =&gt; 65 yrs w/ IZ code/date, if any.</p>
<p><b>Pneumonia Vaccination Status for Older Adults</b> Epidemiology Program/ Amy Groom, MPH</p> <p>Same as Adult Immunizations: Pneumovax in CRS Selected Measures Report but includes less measures</p>	<p><i>Changes from Version 7.0 Patch 1, as noted below.</i></p> <p><b>Denominator:</b> 1) All Active Clinical patients ages 65 or older.</p> <p><b>Numerator:</b> 1) Patients with pneumovax <i>or contraindication</i> documented at any time before the end of the Report period or with a refusal in the past year.</p> <p><b>Definitions:</b> 1) <b>Pneumovax Vaccine/Contraindication/Refusal:</b> Any of the following documented anytime before the end of the Report Period unless otherwise noted:</p> <p>A) <b>Pneumovax Vaccine:</b> 1) Immunization/CVX codes 33, 100, 109; 2) POV V06.6, V03.82 (<i>deleted V03.89</i>); 3) ICD Procedure 99.55; 4) CPT 90669, 90732, <i>G0009, G8115.</i></p> <p><i>B) Contraindication: 1) Contraindication in the Immunization Package of "Anaphylaxis" or 2) PCC NMI Refusal.</i></p> <p>C) <b>Refusal:</b> Any of the following documented during the Report Period: A) Immunization codes 33, 100, or 109, as documented in PCC Refusal File (i.e. REF) or B) Immunization Package as contraindication of "Patient Refusal."</p> <p><b>Patient List:</b> List of patients =&gt;65 yrs w/ IZ code/date, if any.</p>
<p><b>Annual Dental Visit</b> Dental Program/ Dr. Patrick Blahut</p> <p><u><b>Different from</b></u> Access to Dental Services topic in Selected Measures Report</p>	<p><b>No changes from Version 7.0 Patch 1</b></p> <p><b>Denominators:</b> 1) User Population patients ages 3-21, broken down by age groups: 3-6, 7-10, 11-14, 15-18, and 19-21.</p> <p>2) Active Diabetic patients, defined as all Active Clinical patients diagnosed with diabetes prior to the Report period, AND at least 2 visits during the Report period, AND 2 DM-related visits ever.</p> <p><b>Numerator:</b> 1) Patients with documented dental visit during the Report period, including refusals during past year.</p> <p><b>Definitions:</b> 1) <b>Dental Visit:</b> For non-CHS visits, searches for V Dental ADA Code 0000 or 0190; Exam Code 30; or POV V72.2. For CHS visits, searches for any visit with an ADA code. CHS visit defined as Type code of C in Visit file.</p> <p>2) <b>Refusal of Dental Exam:</b> For non-CHS visits, searches for refusal of Exam Code 30 or ADA code 0000 or 0190.</p> <p><b>Patient List:</b> List of patients with documented dental visit only.</p>